STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/31/23 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Emergency Preparedness survey, Briarcliff Health & Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 131 certified beds. At the time of the survey, the census was 75. Quality Review completed on 08/03/23	E 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We kindly request consideration for Paper Compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Christopher A Gill | Administrator | 08/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., the generator lacked weekly inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Supervisor stated that the visual inspections were unable to located during the survey. The findings were reviewed with the Maintenance Supervisor and Regional Facilities Director at the exit conference.	E 0041	**E 041 Hospital CAH and LTC Emergency Power** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The facility staff were unable to locate the missing two inspections of 52 but believe they were conducted during their specified week. We are not aware that any residents were affected by this deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* · *Maintenance Director is responsible for and continues to conduct the required weekly inspection of the Generator, per schedule in TELS, our preventive maintenance software.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	08/31/2023

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			· The Executive Director re-trained the Maintenance Director and Assistant on the generator inspection policies and practices. · The weekly generator inspection form is listed in TELS, our preventive maintenance software; as a weekly task. The administrator and Maintenance Director also receive a weekly report by email on Sundays noting any unfinished or past due tasks. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** · The Executive Director is using an audit checklist to verify that certain Life Safety tasks, including the weekly generator inspection, are completed. They also receive a report and email from the TELS system noting any past due or unfinished tasks. · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance:**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/31/23 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Life Safety Code survey, Briarcliff Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 131 and had a census of 75 at the time of this survey. At the time of this survey, Halls 100 and 200 were unoccupied and experiencing significant and comprehensive remodeling. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.	K 0000	**8/31/2023** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We kindly request consideration for Paper Compliance.	

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	Quality Review completed on 08/03/23			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through gated exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents and staff at the facility.	K 0222	**K 222 Egress Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The padlocks with keys that were being used to secure the three different courtyard gates were immediately removed They were replaced with simple four	08/31/2023

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	Findings include: Based on observation and interview during the facility tour with the Maintenance Supervisor and Regional Facilities Director on 07/31/23 between 10:50 a.m. and 3:00 p.m., the gates exiting from the facility's courtyards (Therapy Courtyard and Courtyard with the Gazebo) to the public way, were equipped with pad locks requiring a key. Additionally, the courtyard gate from the Main Therapy Courtyard near the 700/800 nurses station led to the public way was locked with a pad lock on the outside of the gate and was not accessible from inside the courtyard. When interviewing the Maintenance Supervisor, they stated that the employees who have access to the keys are the Maintenance Supervisor and Business Office Manager. When interviewing the Business Office Manager, they stated that in the event of evacuation, a charge nurse would have to be sent to their office to unlock the office to then grab the key so that they would be able to unlock the gates for evacuation. The keys would not be readily accessible for all staff and would delay evacuation of the facility in the event of an emergency. Both the Maintenance Supervisor and Regional Facilities Director acknowledged the issues at the time of observation. This finding was acknowledged by the Regional Facilities Director and Maintenance Supervisor at exit conference. 3.1-19(b)		digit combination locks. The code is printed on the padlock and on the courtyard gate. The padlocks were placed on the inside of the courtyard gate. We also maintain a key code log that lists each lock, their location and the code, in case the locks lose their code or become unreadable. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* · *The Maintenance Director conducted an end-to-end facility property inspection and removed a total of five (5) padlocks with keys. They were replaced with simple four-digit combination locks that included printing the code on each lock and on the gate itself.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The maintenance staff were inserviced on the use of proper locks and the ongoing monitoring of the courtyard gates and locks. · Courtyards and Gates are reviewed weekly, per inspection	

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			schedule as listed in TELS, our preventive maintenance software. Completion notes are logged into TELS. Any concerns identified are immediately corrected. · All Staff were made aware of the change via memo, posted notice, and payroll message. It was also reviewed at an All Staff meeting. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** · The Executive Director/designee will conduct a weekly walking rounds audit of the courtyard gates to verify that the proper lock is being used. They will quiz six randomly selected staff to verify that they know how to unlock the gate in the event of an emergency. · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	

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K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 1 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects at least 5 staff and an unknown number of residents. Findings include: Based on observation during the tour of the facility with the Maintenance Supervisor between 10:50 a.m. and 3:00 p.m. on 07/31/23, the service hall stairwell exit self-closing door near the kitchen did not latch into the frame after testing three times. Based on interview at the time of observation, the Maintenance Supervisor stated that the closer would have to be adjusted. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b)	K 0225	**K 225 Stairways and Smokeproof Enclosures** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · **The self-closing door was adjusted and now latches into the frame, per specifications.** **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* · *The Maintenance Director did a walking rounds audit and checked all self-closing doors to ensure that they properly latched and sealed. Any concerns were promptly addressed.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All self closing doors are	08/31/2023

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			reviewed weekly, per inspection schedule as listed in TELS, our preventive maintenance software. Completion notes are logged into TELS. Any concerns identified on tour are immediately corrected. · The Administrator and Maintenance Director also receive a weekly report by email on Sundays noting any unfinished or past due tasks. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** · The Executive Director/designee will conduct a weekly walking rounds audit and verify by sample that the self-closing doors shut and seal per specifications. Any identified concerns are to be promptly resolved. · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	

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K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 exit signs were continuously illuminated. This deficient practice could affect approximately 2 staff and an unknown amount of residents. Findings include: Based on observations on 07/31/23 during a tour of the facility from 10:50 a.m. to 3:00 p.m. with the Maintenance Supervisor and Regional Facilities Director, the exit sign above the exit door leading out of the 200-Hall was not illuminated. Based on an interview with the Maintenance Supervisor at the time of observation, the Maintenance Supervisor stated that the light is potentially burned out. The 200-Hall is a portion of an unoccupied section of the building. The area, along with the Classroom Hall, These wings are said to be separated from the remaining building by a 2-hour fire barrier. However, based on review of a floor plan provided, it was unable to be confirmed whether the two wings were completely separated by a 2-hour fire barrier. Furthermore, a wall that is shared between the main dining area and a room next to the 200-Hall nurses station had exposed wood studs and framing. It was unable to be confirmed if that wall was a part of a 2-hour	K 0293	**F 293 Exit Signage** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Power was restored to exit signs in closed unit, ensuring there is proper sign illumination at all times. · Regional Facilities Director notified company architect, who in turn, did a site visit and made recommendations to ensure that closed 100/200 unit area has proper 2-hour fire barrier. Contractor has been hired to make necessary corrections to barrier wall in question. Work will be completed by August 31, 2023. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?**	08/31/2023

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	separation barrier. During the interview, the Regional Facilities Director stated that there is a 2-hour fire barrier, but was unable to confirm that with any documentation. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1.19(b)		· *All residents have the potential to be affected by this alleged deficiency.* · *The Maintenance Director did a walking rounds audit and checked all exit doors to ensure they had the appropriate signage and that they were properly lit. No additional concerns were found.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All exit doors and signs are reviewed weekly, per inspection schedule as listed in TELS, our preventive maintenance software. Completion notes are logged into TEL. Any concerns identified on tour are immediately corrected. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** · The Executive Director/designee will conduct a weekly walking rounds audit and verify that all exit and no exit signs ae in place and lit where appropriate. Any identified concerns are to be promptly resolved. · The Maintenance Director/designee will report on corrections made and ongoing	

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			progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances	K 0345	**K 345 Fire Alarm System – Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Required fire alarm inspection was completed on 8/7/2023. Copy of report attached. · Facility notes that fire alarm inspections got off-schedule during COVID emergency period due to staff shortages by vendor. We were also unable during that time	08/31/2023

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	e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to an annual fire alarm inspection dated 05/10/22. The visual inspection should have been conducted around November of 2022. Based on interview at the time of records review, the Maintenance Supervisor stated that there are fire alarm visual inspections on 'TELS' that are recorded but does not show if the devices passed or failed nor was an itemized list. Further discussion with the Regional Facilities Director, he stated that there has been a change with the process of documenting a visual inspection, but that was not used when it was originally due. This finding was reviewed with the Administrator and Director of Facilities at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include:		to find an alternate vendor as others were reporting staff shortages. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All required fire alarm testing and inspections are listed in TELS, our preventive maintenance software; with email reminders sent to maintenance, administrator, and corporate office. The administrator and Maintenance Director also receive a weekly report by email on Sundays noting any unfinished or past due tasks. · We have re-confirmed with our vendor their ability to meet the necessary inspection requirements and set dates on our calendar for the next twelve months. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Based on record review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., the latest documented annual fire alarm inspection was dated 05/10/22. Based on interview at the time of record review, the Maintenance Supervisor confirmed that the only documentation he had was in the binder and could not locate any fire alarm report dated within the last 12 months. This finding was reviewed with the Maintenance Visor and Regional Facilities Director during the exit conference. 3.1-19(b)		**assurance program will be put into place?** · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components	K 0353	**K 353 Sprinkler System – Maintenance and Testing**	08/31/2023

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	had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., there was no quarterly sprinkler system inspection report available for the first quarter (January, February, and March) of 2023. During an interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been inspected during the first quarter of 2023 and further stated that he was		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Required sprinkler inspections were completed on 8/7/2023. See attached. · Facility notes that fire sprinkler inspections got off-schedule during the COVID emergency period due to staff shortages by vendor. We were also unable during that time to find an alternate vendor as others were reporting staff shortages. · Facility leadership obtained a copy of the facility's last required 5-year internal pipe inspection, which was conducted on November 15, 2020. See attached. · Regional Facilities Director notified the company architect, who in turn, did a site visit and made recommendations to ensure that closed 100/200 area has proper 2-hour fire barrier. The contractor has been hired to make necessary corrections to the shared barrier wall in question. They are also removing the unused and unnecessary metal ceiling frames. Work will be completed by August 31, 2023. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	

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	unaware if the sprinkler company had done the inspection due it being done before his employment date. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b) 2. Based on record review, observation, and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., documentation of a 5-year internal pipe inspection was unable to be located at the time of record review. During a tour of the facility between 10:50 a.m. and 3:00 p.m., metallic sprinkler piping was noted throughout the basement and a room on the second floor deemed the "COVID storage room." The rest of the first floor of the facility did have PVC sprinkler piping. Furthermore, no tag or sticker was located on the sprinkler riser to determine if the facility has had an internal pipe inspection done. Based on interview at the time of record review, the Maintenance Supervisor was unaware if the		**correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All required fire sprinkler testing and inspections are listed in TELS, our preventive maintenance software; with email reminders sent to maintenance, administrator, and corporate office. The administrator and Maintenance Director also receive a weekly report by email on Sundays noting any unfinished or past due tasks. · We have re-confirmed with our vendor their ability to meet the necessary inspection requirements and set dates on our calendar for the next twelve months. · It is the facility's intent to not use 100/200 wing currently and to classify it as a closed area that is not accessible to staff/residents/visitors. All Staff have been instructed that this wing is off limits, signs have been posted indicated doors are not a fire exit and a lock system is in place to maintain security. **How the correction actions will**	

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	sprinkler system has had an internal pipe inspection done within the last 5 years. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction of 2 of 2 corridors. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects approximately 10 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Regional Facilities Director on 07/31/23 between 10:50 a.m. and 3:00 p.m., two unoccupied wings are located on the west side of the building listed as 200-Hall and the other as classroom areas based on floor plan. During the tour, both wings had no ceiling tiles within the corridors of both wings. It was estimated that approximately 200 ceiling tiles were missing from both wings. Floor plans were provided during the survey had indicated that there was a fire barrier located between the two unoccupied wings and the Service Hall by the kitchen. However, the floor plan did not specify if both wings were completely separated by a 2-hour fire barrier. Furthermore, a shared wall between the dining area and the adjacent unoccupied space on		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	

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	the floor plan was unable to be determined if it was within a 2-hour wall. Potentially leaving a lack of separation between the two areas. This required both areas to be surveyed while under a remodel. Based on interview at the time of observation The lack of ceiling tiles could cause a condition that could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Regional Facilities Director acknowledged the missing ceiling tiles in the wings but stated that there is a 2-hour separation between both wings, but documentation did not state nor confirm that they were completely separated from the rest of the building by a 2-hour fire barrier. The finding was reviewed with the Maintenance Supervisor and Regional Facilities Director during the exit conference. 3.1-19(b)			
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 1 of 1 office doors. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Supervisor on 07/31/23 between 10:50 a.m. and 3:00 p.m., the office of the Unit Coordinator next to resident room 508 had the door held open with a wooden door wedge, and the door would not	K 0363	**K 363 Corridor - Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The door was adjusted and closes and latches appropriately. Staff were instructed to not prop door open using a wedge or similar weighted item but to keep door always closed. **How will you identify other**	08/31/2023

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	close by just pulling or pushing the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned issue. This finding was reviewed with the Maintenance Supervisor and Regional Facilities Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 25 of 26 corridor doors in the 200 wing and the classroom wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Supervisor and Regional Facilities Director on 07/31/23 between 10:50 a.m. and 3:00 p.m., all corridor doors noted in the 200-Hall and Classroom Hall were noted to either be non-latching due to no latching hardware, doors were noted to have penetrations from missing door handles or hardware, and it was observed that a number of doors were missing from the leaf exposing the room to the corridor. These unoccupied wings are considered under remodel. The two wings are said to be separated by the remainder of the building by a 2-hour fire barrier. However, based on review of a provided floor map, it was unable to be determined whether there is a confirmed 2-hour fire barrier, so the areas were a part of the surveyed. Furthermore, a wall that is shared in the main dining area and an unoccupied		**residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* · *The Maintenance Director conducted an end-to-end facility inspection and confirmed that all doors could close without impediment to the closing of the door unless they have a self-closing device or powered door mechanism.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All exit doors and signs are reviewed weekly, per inspection schedule as listed in TELS, our preventive maintenance software. Completion notes are logged into TELS. Any concerns identified on the tour are immediately corrected. · All Staff were made aware of the change via memo, posted notice, and payroll message. It was also reviewed at an All-Staff meeting. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	space near the 200-hall nurses' station was observed as drywall. However, the wall was visible studs and framing, but was unable to be confirmed if that too is a 2-hour separation. The floor map provided could not determine if that shared wall was also a 2-hour barrier. Based on interview at the time of observations, the Regional Facilities Director stated that there is a 2-hour separation between the main building and the unoccupied spaces for both wings, however he acknowledged that the documentation provided did not confirm if both wings were within a 2-hour separation. The finding was reviewed with the Regional Facilities Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**assurance program will be put into place?** · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 2 of 2 fire dampers were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard	K 0521	**K 521 HVAC** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · **Fire Dampers were previously inspected in 2021 and were inspected again in August 2023. No concerns were noted.**	08/31/2023

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	for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect approximately all residents and staff. Findings include: Based on records review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., no documentation of an inspection for the smoke/fire dampers in the 700/800 halls and the service hall were available for review. Based on observation with the Maintenance Supervisor between 10:50 a.m. and 3:00 p.m., there was a smoke/fire damper in the duct work between the 700/800 smoke barrier and the barrier that separated the service hall from the unoccupied wings. Based on interview at the time of records review and observation, the Maintenance Supervisor stated the damper inspections could not be found and was unaware if there were other fire dampers located within the facility. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference.		**How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The fire dampers are listed in TELS, our preventive maintenance software. Completion notes are logged into TELS. As noted the inspection was done on August 7, 2023; next inspection will be conducted in the summer of 2027 **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Executive Director will confirm whenever updating the facility's Survey Readiness Binder that the damper inspection is on file and current. · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI	

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	3.1-19(b)		meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area	K 0711	**K 711 Evacuation and Relocation Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · We updated the facility's Fire Plan to include locations of smoke/fire barriers. All maps in binders were updated with new detail.	08/31/2023

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	(7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., the facility provided information on evacuation of smoke compartments but did not address the locations of smoke/fire barriers. Based on interview, the Maintenance Supervisor stated they were unaware of the missing information and further stated that that's the only fire plan that he knew of. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The facility's Safety and QAPI Committees review the Evacuation and Relocation Plan as part of their regular review of our Emergency Preparedness Plan. The EPP is multi-faceted and includes items covered by K 711. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Executive Director will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make	

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			recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so	K 0761	**K 751 Maintenance, Inspection and Testing - Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · **A**nnual Inspection and Testing of 5 of 5 fire doors was completed on August 7, 2023. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All exit doors and signs are reviewed weekly, per inspection schedule as listed in TELS, our preventive maintenance software.	08/31/2023

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	equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect approximately all residents and staff. Findings include: Based on record review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., no documentation of an annual inspection for the (5) fire door assemblies was available for review. Based on observation during the tour between 10:50 a.m. and 3:00 p.m., there are (4) three hour fire door assemblies in the one stairwell and one corridor separation door and the oxygen storage room. There was also (1) 3/4 hour fire door located next to the 700/800 hall. Based on interview at the time of records review and observation, the Maintenance Supervisor agreed that fire door inspections were unable to be		Any identified concerns are immediately addressed. **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	

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	located and stated that if fire doors inspections were completed it was before he was hired. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b)			
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels			

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	and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 2 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Supervisor on 07/31/23 between 08:40 a.m. and 10:47 a.m., visual inspections for the weeks of September 4, 2022, and February 12, 2023, documentation for the natural gas generator was unable to be reviewed during record review. The Maintenance Supervisor did state that all of the weekly inspections were documented on the computer program 'TELS'. When looking through the 'TELS' system, the status of the two weeks was noted as not recorded. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the missing documentation and was unaware if it was	K 0918	**K 751 Maintenance, Inspection and Testing - Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · **A**nnual Inspection and Testing of 5 of 5 fire doors was completed on August 7, 2023. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · *All residents have the potential to be affected by this alleged deficiency.* **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All exit doors and signs are reviewed weekly, per inspection schedule as listed in TELS, our preventive maintenance software. Any identified concerns are immediately addressed.	08/31/2023

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	completed due to the inspections would have been done before his employment. Findings were discussed with the Maintenance Supervisor and Regional Facilities Director at exit conference. 3.1-19(b)		**How the correction actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will report on corrections made and ongoing progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/31/2023**	